III. RATE REVIEW

A. Rebase of Cost Data

The prospective rates will be recalculated and ceilings will be rebased every three years using the most recent audited provider cost reports. The rates and the ceilings will be inflated in interim years.

B. New Agencies

1. "New agencies" are home health providers which newly enroll in Medicaid after the last rate calculation. They may be newly operational and unable to document 12 months of operational costs, or be existing agencies which newly enroll with Medicaid.

2. New agencies with a year or more experience are required to submit an audited cost report at the time of enrollment. If the initial report representing a full year of operational costs is submitted in an interim year, the agency will be reimbursed their inflated reported costs, up to the inflated ceiling.

3. If the agency has not been operational for a full year, they must submit a report of estimated costs. These agencies will be reimbursed the lower of their estimated costs or the ceiling for each discipline for the first year until they submit a cost report representing a full year of operation. An average cost per visit, or average cost per hour for home health aide, will be calculated from the initial cost report.

Prescribed Pediatric Extended Care Centers (PPECCs) will be reimbursed at a negotiated range of daily rates depending on the level of care needed by each child.

DELAWARE RATES FOR PEDIATRIC CARE (con't)

Immunizations (con't)

90720	Diphtheria, tetanus, and pertussis (DTP) and Hemophilus influenza B (HIB) vaccine *Code not currently used*◊	
90724	Influenza virus vaccine	$ 4.38◊
90725	Cholera vaccine	IC*
90726	Rabies vaccine	$ 93.00
90727	Plague vaccine	IC*
90728	BGC vaccine	IC*
90730	Hepatitis A vaccine	IC*◊
90731	Hepatitis B vaccine	$ 11.50◊
90732	Pneumococcal vaccine, polyvalent	$ 8.60
90733	Meningococcal polysaccharide vaccine (any group(s))	$ 45.00
90737	Hemophilus influenza B *Code not currently used*◊	
90741	Immunization, passive; human (ISG)	$ 38.00◊
90742	Specific hyperimmune serum globulin	IC*◊
90749	Unlisted immunization procedure	IC*

*IC = individual consideration

◊ = Effective 1/1/95, these codes used for administration fee only due to implementation of Vaccines for Children Program.

DELAWARE RATES FOR PRIVATE DUTY NURSING

Private Duty Nursing Services, whether performed by a provider located in Delaware or a provider with an out-of-state location, are reimbursed at a capped hourly rate with weekly maximum dollar limit per client, as set by the Delaware Medicaid Program. The hourly rates are reviewed whenever a rate increase is requested by a provider, but no more frequently than annually, by conducting a survey of the agencies that provide private duty nursing services and capping the rate at the lowest level available of these prevailing rates. The weekly maximum dollar limit is derived by multiplying the capped hourly rate by the minimum number of hours necessary to maintain the client in the home as an alternative to institutionalization, but not to exceed eight (8) hours daily.

Reimbursement for Assistive Technologies and Supplies

DURABLE MEDICAL EQUIPMENT (DME), SUPPLIES, APPLIANCES, ORTHOTICS AND PROSTHETICS

The Delaware Medical Assistance Program (DMAP) will reimburse DME providers for the purchase/rental of medical equipment, appliances, orthotics and prosthetics and the purchase of medical supplies when ordered by a medical practitioner.

Reimbursement is determined by the DMAP based on one of the following:

- The Medicare fee schedule received yearly from the Region A - Durable Medical Equipment Regional Carrier (DMERC) OR
- A nationally recognized pricing system OR
- Information received from the DME provider such as catalog pages that include manufacturer's name, item model number, and costs or a copy of the company's invoice that describes the item and gives an itemized explanation of all charges. (It is not permissible for the DME provider to "roll in" other expenses such as labor, delivery, fittings, etc.

Except where there is a Medicare fee established, DMAP pays the lower of:

- Provider's usual and customary charge charges
- Cost + 20% (includes administration fee)
- List price.

AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICES/SYSTEMS

The reimbursement for augmentative and alternative communication devices / systems is determined based on documented actual cost to the provider for the device plus 20% on the first $1,000 and 5% on the balance, or the provider's usual and customary charge for the device, whichever is lower.

Certified Nurse Practitioners will be reimbursed in the same way that physicians are reimbursed, the lesser of their usual and customary charge or the capped fee per HCPCS procedure code.

FEDERALLY QUALIFIED HEALTH CENTERS

Federally Qualified Health Centers are reimbursed 100% of their reasonable costs of providing health services to Medicaid beneficiaries. FQHCs are assigned a prospectively determined rate per clinic visit based on actual costs reported on their audited cost report from their most recent fiscal year. Primary Care costs are separated from Administrative and General costs for purposes of rate calculation. The Administrative and General component is capped at 40% of the total cost. Each cost component is inflated by the current U.S. Consumer Price Index. The total inflated cost of the components is divided by the number of patient visits to determine the prospective reimbursement rate. Costs reports submitted by FQHCs are subject to audit by the State.

State/Territory DELAWARE

Reimbursement for pharmaceuticals:

Overview
The Delaware Medical Assistance (DMAP) program will reimburse pharmaceuticals using the lower of

- the usual and customary charge to the general public for the product,
- the Average Wholesale Price (AWP) minus 12.9% plus a dispensing fee, or
- a State-specific maximum allowable cost (DMAC) and, in some cases, the federally defined Federal Upper Limit (FUL) prices plus a dispensing fee.

Entities that qualify for special purchasing under Section 602 of the Veterans Health Care Act of 1992, Public Health Service covered entities, selected disproportionate share hospitals and entities exempt from the Robinson-Patman Price Discrimination Act of 1936 must charge the DMAP no more than an estimated acquisition cost (EAC) plus a professional dispensing fee. The EAC must be supported by invoice and payment documentation.

Definitions:
Delaware Maximum Allowable Cost (DMAC) - The DMAC payment limits will be calculated, for drugs selected by the DMAP, by First Data Bank (FDB) under contract with Delaware Medicaid using the following protocol.

- All DMACs will be based on the direct prices.
- FDB will use the lowest of either Geneva Generic or Rugby prices. These are national generic labelers/manufacturers that sell directly to pharmacies.
- Prices for solid dosing forms will be based on a package size of 100. If that size is not available, the next largest package size will be used.
- Prices for liquid products will be based on 120 ml for over-the-counter (OTC) medications and 473 - 480 ml for legend products.
- All unit dose packaging calculations will be eliminated.
- If neither identified labeler markets the product, the median of all other HCFA rebate participating sources will be used to establish a price.

Drugs are selected based on experience with charges from pharmacies which indicates that the product cost is less than or equal to AWP minus 20%.

Additional medications will be added to the DMAC program after general provider notification.

Federal Upper Limit (FUL) - The FUL is a federally defined price and constitutes the upper limit of reimbursement where a DMAC limit does not exist.

<continued on page 14a>

Reimbursement Policy:

- Pharmacy providers are free to dispense any product they wish (within the limits of State and federal laws governing pharmacies), but the DMAP payment will not exceed the limits identified above.
- The limits apply to all drugs listed in Appendix B (FUL/MAC listing containing the generic name and upper limit/unit source) of the Pharmacy Provider Manual, including brand and substitutes/generics.
- State DMAC/FUL limits do not apply to drugs in unit dose packages
- Medicaid reimbursement is limited to only those drugs supplied from manufacturers that have a signed national agreement or an approved existing agreement under Section 1927(a) of the Social Security Act. Restrictions in drug coverage are listed on Page 5 Addendum of Attachemtn 3.1-A of this Plan.

Exceptions:

- Exceptions to the reimbursement limits can be made if a physician certifies in his/her own handwriting that a specific brand is medically necessary for a particular recipient.
- A check-off box is NOT acceptable.
- A notation of intent in the prescribing physician's own handwriting (such as, "brand necessary", "brand only", dispense as written") IS acceptable (42 CFR §447.331).
- Phone-in prescriptions which qualify for an exception must be followed by the proper certification written by the prescriber.
- Faxed prescriptions must follow Board of Pharmacy regulations.

When an exception exists and a pharmacist wishes to override the limit due to the medical necessity of using the brand name product, refer to the billing section of the Provider Manual for instructions on the proper coding of the claim.

If the pharmacist is not willing to accept the DMAP's DMAC/FUL payment when a prescription is received for a brand name product with no substitutions permitted AND the physician has not indicated that the brand is medically necessary according to the above instructions, the pharmacist should:

- contact the physician to obtain proper written documentation, or
- refer the recipient to another pharmacy that may be willing to fill the prescription for the DMAC price, or, as a last resort,
- request full payment from the recipient for the product.

State/Territory: DELAWARE

DRUGS:

Effective 10/31/87, multiple source drugs are reimbursed in accordance with Section 6305 of the State Medicaid Manual issued by HCFA with charges being monitored on a per claim basis and being paid at the lower of actual acquisition cost (AAC) plus a dispensing fee, usual and customary charge to the general public, or the HCFA upper limit plus a dispensing fee. Multiple source drugs where the brand name is properly certified as medically necessary by the physician in the physician's own handwriting, and single source drugs, are reimbursed at AAC plus a dispensing fee or the usual and customary charge to the general public, whichever is lower. The dispensing fee is generally $3.65. However, if the State is unable to procure prescription items at the usual dispensing fee, it will, through its pharmacy consultant, negotiate acceptable payment levels.

Effective 1/1/91, Medicaid reimbursement is limited to only those drugs supplied from manufacturers that have a signed national agreement or an approved existing agreement under Section 1927 (a) of the Social Security Act. Restrictions in drug coverage are listed on ATTACHMENT 3.1-A, Page 5 Addendum of this Plan.